“EXHIBIT J”

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EDGAR SOLIS, Plaintiff, vs. COUNTY OF RIVERSIDE; STATE OF CALIFORNIA; SALVADOR WALTERMIRE, MICHAEL BELL, and DOES 1-10, inclusive, Defendants.	Case No. 23-CV-00515-HDV-JPR

REMOTE VIDEOCONFERENCE DEPOSITION OF

MICHAEL RITTER, M.D.

FRIDAY, JULY 26, 2024

Reported Stenographically By:

Jinna Grace Kim, CSR No. 14151

Job No.: 86900

A. Yes.
Q. If you need a break at any time, will you let me know?
A. Yes, I will. Thank you.
Q. And if you don't understand any of my questions, will you let me know that as well?
A. Yes.
Q. Have you been retained as a medical expert by the Defense in this case?
A. Yes.
Q. Who retained you?
A. Mr. Klehm.
Q. And do you understand approximately when he retained you?
A. I'm looking at my billing invoices; May of 2024.
Q. Is this the first case that you have with Mr. Klehm?
A. In his current capacity, yes. I worked with him in the past when he was a defense attorney for medical malpractice case.
Q. How many times have you worked with Mr. Klehm before?
A. I think twice.
Q. How many times have you been retained if at all by the CHP?

A. This is the first time.

Q. Have you been retained as an expert at all in any other officer-involved shooting cases?

A. Yes.

Q. How many officer-involved shooting cases?

A. Let me think. Actually, they were officer cases where there was a death, but it was not a shooting.

I misspoke, I'm sorry. There were two cases that I was retained.

Q. Was force used in any of two cases that you were retained?

A. Force, let me think about this.

MR. KLEHM: It's vague and ambiguous.

THE WITNESS: I don't -- I mean I just focused on the medical stuff. I don't think so.

BY MR. SINCICH:

Q. Is it fair to say that this is your first officer-involved shooting case?

A. Yes.

Q. Of the other two cases that you had with law enforcement involved, did the subject have either PCP or meth in his system?

A. One of them.

MR. KLEHM: Calls for speculation; lacks foundation.

BY MR. SINCICH:

Q. And were you retained in that case to opine on the effects of PCP or meth on that subject's system?

A. No.

Q. I read your report that you had over a 100,000 patients; is that about right?

A. Yeah. I've been practicing medicine for about 30 years now.

Q. Approximately how many of those patients do you know of were under the influence of PCP when you evaluated them?

A. PCP, I would say probably in the range of 50 to 100, maybe more. PCP was a much bigger problem early in my career compared to now.

Q. Is PCP kind of rare now?

A. It's been changed over to Ketamine. So Ketamine is the preferred drug now. We still see PCP, but Ketamine seems to be more popular these days.

Q. Of those approximate 100,000 patients, how many were under the influence of methamphetamine, if you know?

A. Meth patients, oh, boy. I would say more than 500.

It's a pretty common problem we see, could even be close to a 1000.

Q. In any of those patients that you evaluated, were all of those in your capacity as a doctor in the ER?

A. Yes.

Q. Were any of those patients shot by the police?
A. Some were.
MR. KLEHM: Lacks foundation; calls for speculation.
BY MR. SINCICH:
Q. Of the 50 to 100 PCP patients that you experienced approximately, how many were shot by the police?
A. I can't give you an exact --
MR. KLEHM: Same objections.
Sorry, Doctor. If you can just wait a minute.
THE WITNESS: Sure.
MR. KLEHM: Thank you.
BY MR. SINCICH:
Q. Could you give me an approximate number?
A. I cannot.
Q. Okay. What about from the 500 to a 1000 methamphetamine patients, do you have approximate number for that?
A. I don't.
Q. How many current cases do you have right now as an expert witness?
A. Maybe 15 to 20.
Q. Do you know approximately what percentage of your income comes from your medical practice as opposed to your expert witness practice?

A. Medical practice is probably 75 percent of my income.

Q. Do you have any other source of income besides the two?

A. No.

Q. Have you ever been retained by other police agencies in the past?

A. Police agencies, I don't think so.

Q. I think my prior question was just with regard to CHP, but have you had any other officer-involved shooting cases with any other Sheriff's Department or police department?

MR. KLEHM: Objection. Asked and answered.

He's already testified he hasn't.

THE WITNESS: No.

BY MR. SINCICH:

Q. What was your assignment in this case?

A. He asked me to look at the medical records and wanted to know if the effects of the drugs that were detected played any role in his behavior and the number of shots required to immobilize him.

Q. Were you able to determine how many shots were required to immobilize Mr. Solis?

A. No.

Q. Did you write a report in this case?

A. I did.

Q. I don't know if I saw it or not.

Does your report contain your fee schedule?

A. It should. If it doesn't, I can give it to you here.

Q. Do you have your report handy?

A. I have it in front of me, yes.

Q. Could you tell me what page your fee schedule is on?

A. I just have the report. I don't have the exhibits that go with it. So I don't know that -- I don't know if you got it or not. I'm sorry.

Q. How much do you charge for deposition?

A. Deposition $750 an hour.

Q. And what about to testify in court?

A. $3500 per half day.

Q. How much do you charge for your evaluation of a case up to writing the report?

A. $600 an hour.

Q. And I saw that your billing was included, I believe, yesterday.

Do you have any other billing in this case?

A. The only other billing is I spent maybe an hour this morning just reviewing everything in preparation for the deposition, but that's current.

Q. How many hours did you spend on the case from initially taking the case all the way up to turning in the report?

A. Looks like about 8.3 hours billed up -- let's see. I had to create a Rule 26 report -- probably about ten, approximately ten hour.

Q. And then what about from turning in your report until the start of the deposition?

A. About another four hours.

Q. Okay. Does your report list all of your opinions in this case?

A. It does.

Q. Do you plan on giving any other opinions that are not listed in your report?

A. No. Unless there is new materials that are discovered and provided to me, but otherwise, no.

Q. Does your report list all the documents that you replied upon in forming your opinions?

A. Yes.

Q. Is that reflected on Page 2 of your report?

A. Yes. I think the only thing that's not listed here which I talked about in my report is the laboratory drug testing. So it's in the report, but I didn't list it right here.

Q. Did you review any documents since turning in your

report related to this case?

A. Looks like the report of Doctor Ryan O'Conner who is an emergency physician.

Q. Anything else?

A. No. It doesn't appear so.

Q. Did your review Dr. O'Conner's report change your pinions at all?

A. He just talked about the injuries that were obtained.

Q. It's states that you had reviewed the Riverside University Health System Medical Records; is that right?

A. That's correct.

Q. Do you a Bates stamp number of the records that you reviewed?

A. Yeah. There is a Bates stamp at the bottom, yes.

Q. For instance, were you given just a sample of the records, a few 100 pages, or were you given several thousand pages of records?

A. Couple thousand pages of records. There was a lot.

Q. Do you know if the Bates stamp range was 1 through another number that you can give me?

A. I don't without opening the reports of looking at them.

Q. Would that take too long, or do you have them in

front of you? I saw you look down.

A. No. I'm not looking at a report in front of me. I'm looking at my handwritten notes that I did got some Bates stamp pages. It looks like the biggest number that's on here is 2673. So there's at least 2,673 pages of records. It's probably more, but that's the handwritten notes here.

Q. And you reviewed all those medical records?

A. Yes. I looked through them.

Q. And the Ring video that you mentioned in your report, is that the surveillance video that shows front yard of the incident?

A. I think it's the front yard. I don't know.

Q. Do you know if there is a Bates stamp number on the video that you reviewed?

A. I don't believe so.

Q. Do you recall whether or not the video that you reviewed depicted something that occurred before or after the shooting?

A. I think it was after the shooting, but I can't tell you for certain.

Q. In the video were you able to see Mr. Solis at all?

A. No.

Q. Were you able to hear Mr. Solis at all?

A. Yes.
Q. Okay.
A. I'm assuming it's him. I don't see, you know, his lips moving.
Q. What did you hear from Mr. Solis in the video that you reviewed?
MR. KLEHM: Objection. Calls for speculation; lacks foundation.
You can answer.
THE WITNESS: Something about his leg was all that I heard.
BY MR. SINCICH:
Q. And you reviewed deposition of Officer Michael Bell?
A. I did.
Q. Did you review the deposition of Mr. Solis at all?
A. No.
Q. In the beginning of your report it looks like you summarized some of the medical records; is that fair to say?
A. Yes.
Q. Is it fair to say Mr. Solis was shot several times in this incident by law enforcement?
A. Yes.
Q. He had penetrating wounds to his hand, wrist, back,

and buttocks?

A. And leg.

Q. And leg. Do you know how many times he was shot in this incident?

A. I don't.

Q. Do you know approximately how many times?

A. Approximately maybe ten. You know, there is multiple holes, you know, some maybe an entry and exit to maybe a single entrance. So it really wasn't the focus of my report or investigation.

Q. Right. Your focus was more on the effects of drugs that may have on his system?

A. His injuries and then the effects of the drugs, yes, medical stuff.

Q. He was given 15 liters of oxygen?

A. Yes.

Q. Is that standard protocol for someone with injuries like this?

A. Yes, supplemental, oxygen, yes.

Q. And both in route to the hospital and in the trauma, Mr. Solis was in and out of consciousness?

A. That's correct. That's what is described in the records.

Q. Did you find that to be because of the amount of blood that he was losing?

A. No. Because his blood pressure was okay. There were points in the records where he had a normal blood pressure, but they're describing him being in and out of consciousness. That's pretty classic for someone on PCP.

Q. Did you see anywhere in the records that during transport to the hospital his blood pressure actually dropped?

A. It did, yes. I saw that.

Q. Did that result in him going in and out of consciousness.

A. If it went below 60, yes, which it did not.

Q. Could a person being shot after being shot approximately ten times?

A. It could, yes.

Q. Is shock a deadly symptom?

A. It can --

MR. KLEHM: Objection. Incomplete hypothetical; lacks foundation calls for speculation.

BY MR. SINCICH:

Q. I'm sorry. What was your answer, Doctor?

A. It can be.

Q. Could a person appear to be going in and out of consciousness if they're in shock?

MR. KLEHM: Objection. Incomplete hypothetical;

on his X-ray when he got to the trauma center, but if somebody is shot in the chest and particularly if there is any issues about stability, one of the things that can be done is to prophylactically place a needle into the chest to release the air if there is a tension pneumothorax.

Q. Is this fair to say that EMS thought it was medically necessary because of the shot to Mr. Solis's back?

MR. KLEHM: Objection. Calls for speculation.

THE WITNESS: I don't know what their thought process was when they did that. The medical explanation that we commonly see is if you have a person that's got a penetrating injury to their chest and -- stability, that's one of the options of things that you could do is to put a needle into the chest.

BY MR. SINCICH:

Q. Did you find that Mr. Solis was shot in the chest at all?

A. Shot in the back.

Q. Right. So generally his chest cavity in the back --

A. Yes. Your chest is, you know, there's front part and the back part. So when we say the back, a lot of people think of the low back down by where your belt is, but his area was actually part of the chest.

Q. From your assessment in the medical records, is it

fair to say that Mr. Solis was severely injured from being shot by law enforcement officers?

A. Yes.

Q. And were his injuries life-threatening from your review of the records?

A. Not life-threatening. He didn't have any major internal injuries to his abdomen, chest, or brain, or spinal column.

Q. If he wasn't immediately treated, for instance, to stop the bleeding, could he have died?

MR. KLEHM: Objection. Incomplete hypothetical; calls for speculation; lacks foundation.

THE WITNESS: Yes.

BY MR. SINCICH:

Q. Now, you mentioned that you saw the Biotox Laboratory report; right?

A. I did. I got it right here.

Q. Do you know the threshold for detection of PCP and methamphetamine that Biotox Laboratory uses?

A. No. It's not listed on the report.

Q. Do you know if there is a general number from your experience that labs would use?

A. There are, but I don't know those reference ranges off the top of my head.

Q. In your experience in the ER, I think you said you

had like 30 years of experience in the ER?

A. Yes.

Q. Is it fair to say that in the ER generally only a qualitative measure of drugs like PCP and methamphetamine is conducted?

A. Usually that's what we start with. If there is questions we will do blood levels as well, but the standard order set for a trauma patient as an addition to our routine lab testing for trauma-related injuries, we automatically get a alcohol level and then a urine drug screen.

That's more for education and intervention, you know, at least we know, because I've always worked at a trauma center my whole career is that a lot of the trauma victims are under the influence of drugs or alcohol, and we use that as an educational opportunity to get counselors to see them while they're in the hospital to help with to prevent them from using drugs again and help them with sobriety.

Q. So is it fair to say that generally speaking with a trauma patient, for instance, in a gunshot wound patient, the quantity of the drugs is not relevant to the medical procedures that the trauma surgeons are going to perform?

MR. KLEHM: Objection. Incomplete hypothetical.

THE WITNESS: Well, actually no. If you take it just for the trauma standpoint, so let's say that you got an

automobile accident and your spleen's ruptured, and you need to go to surgery, it doesn't matter what the drug level is. You're still going to take them to surgery and stop the bleeding of the spleen.

But if there are -- you know, if the patient's unstable, and you can't find an explanation that's related to trauma for their instability, then we start to look at is this a toxicological problem that's causing their instability.

So it's part of the thought process, but generally, the answer to your question is yes. We treat the trauma patient independent of the effects of drugs and alcohol.

Q. Did you see from your review of the records that there was any specific procedure what was performed because Mr. Solis's urine resulted in a positive hit for meth or PCP?

A. You mean the administration of medications, or what are you referring to when you say procedure?

Q. Anything that you found that they did specifically because of that positive hit.

A. There were multiple social worker visits, and they're usually the ones who will talk to people and do all of our drug and alcohol talk and counseling, but I don't have those records in my fingertips memorized. So I can't tell you exactly what happened there.

Q. Outside of the social workers particularly with regard to the doctors, did they do anything different because -- from your review of the records, because Mr. Solis had a positive hit for methamphetamine or PCP?

A. We focus on the medical issues. Once they're stabilized medically and they leave the hospital, then that's where a lot of the work is done after the fact.

Q. Is it fair to say that the same procedures would have taken place even if medically speaking even if Mr. Solis did not have methamphetamine or PCP in his blood?

MR. KLEHM: Objection. Incomplete hypothetical; lacks foundation; argumentative; calls for speculation.

But you can answer.

THE WITNESS: Those are standard tests that we do on every single trauma patient that comes in. So yes.

BY MR. SINCICH:

Q. And outside the tests, the surgeries, and the treatment thereafter, that all would have been the same as well?

MR. KLEHM: Objection. Incomplete hypothetical; lacks foundation; calls for speculation; it's argumentative.

THE WITNESS: Yes.

BY MR. SINCICH:

Q. Is PCP considered a dissociative anesthetic?

A. It is.

Q. Does that mean that it could be used essentially for sedative purposes?

A. Yes, it can. It's not used for that now.

That's what it was developed for in the 1950's, but there were so many side effects that it never got FDA approval to be used in humans.

Q. Right. It used to be used like a tranquilizer as well?

A. It was never FDA-approved. So it was not used.

In research studies, it was, but PCP was never a drug that was used by the medical community other than in a laboratory research setting.

Q. Okay. And generally, it can be consumed in various different ways such as injection, inhalation, or being smoked?

A. That's correct.

Q. I think in your report you mentioned that the inhalation is the most common one?

A. Yeah. People like to put PCP in either tobacco or used to popular dip Sherman cigarettes. I don't know if you remember Sherman, if you're old enough for that. You look pretty young, but Sherman cigarettes, they would dip it in liquid PCP and smoke that. That was a common way to do it.

It could also be found in marijuana.

Q. And that's important to know in the analysis because inhalation, the effects occur within two to five minutes, whereas if it's injected, it might take as long as an hour for the effects to kick in?

A. Did you say injected or ingested?

Q. Injected.

A. No. Injected is immediate. So if you inject PCP, the effects would be immediate. Then the next fastest is smoking, and then take it orally takes longer.

Q. So ingestion might take up to an hour for it to kick in?

A. Potentially, yes. It depends on a lot of the factors with a drug taken orally, whether or not you have a empty stomach, whether or not there's a lot of water taken with it, so on and so fourth.

Q. Is it fair to say that drugs effect people differently?

MR. KLEHM: Same objections. Incomplete hypothetical; lacks foundation; calls for speculation.

THE WITNESS: They do.

BY MR. SINCICH:

Q. Is it fair to say that you can't say exactly how these drugs effected Mr. Solis on the day of the incident?

MR. KLEHM: Same objections.

THE WITNESS: No. So the first thing I would say is

that even though his blood pressure was stabilized after the IV fluids and the blood transfusion, he was still very tachycardic, meaning, a fast heart rate. I think it was 150 before they put him on a ventilator. And that is commonly seen with both PCP and crystal methamphetamine. So that's the first.

The second is the in and out of consciousness we talked about that's classic for PCP. In fact, early in my career when we saw a lot more people that were doing PCP, we would precautionarily place them into physical restraints in the ER because they would be seemingly completely calm, and then ten minutes later they're wild animal going nuts.

And so we would do precautionary restraints even if they had calm behavior because we had staff members attacked, people trying to run out of ER, all kinds of crazy stuff.

BY MR. SINCICH:

Q. Did you see any evidence in the records that Mr. Solis acted like a wild animal at any point in time?

A. No. In fact, it was just the opposite. He was calm, and asking for a glass of water despite having all these injuries and multiple fractures which are very painful.

Q. Did you see any evidence that he was attempting to attack anybody while in the trauma bay at the ER?

A. No.

Q. Did you review any evidence that Mr. Solis was in and out of consciousness before being shot by the police?

A. No --

MR. KLEHM: Objection -- hang on. Sorry.

Argumentative; assumes facts not in evidence; lacks foundation; calls for speculation.

THE WITNESS: No. I just looked at the medical stuff. I did not look at that.

BY MR. SINCICH:

Q. Would you expect that a person on PCP to be in and out of consciousness whether or not they were shot by the police?

A. It's possible. Everybody's different when they're high on PCP. It's a bizarre drug. It's a drug that some people are just kind of high and they're peaceful.

There is other people that are completely crazy, they never slow down, and have to be immobilized and we have to give them strong tranquilizers or general anesthetics to put them out until the drug is cleared out of their system.

And then there's people in the middle that they fluctuate and they wax and they wane. So they can be calm and they can be wild. So there is a whole variation of presentation of people that are high on PCP.

Q. Is it fair to say that because everybody's different, you can't opine as to how Mr. Solis was feeling

the effects of PCP or methamphetamine on the day of the incident?

A. No. I can opine on that. That's he had multiple extremity fractures, a rib fracture, including a tibia fracture which is the long bone between your knee and your ankle. Those are extremely painful when they break, and there is no evidence that he was hollering out in pain when he was in the ER. In fact, he was calm and seem to be asking for a glass of water which is to me something that's more consistent with somebody that is high on PCP as opposed to someone who is completely sober.

Q. Is it possible for someone to be in pain and ask for water while in the ER?

MR. KLEHM: Same objections. Incomplete hypothetical; calls for; speculation Lacks foundation.

THE WITNESS: I mean I suppose so. Usually, they're asking for pain medicine or hollering out that they're in agony.

BY MR. SINCICH:

Q. Do you know what time Mr. Solis asked for water?

A. You just froze. I didn't hear any of that.

Q. Thanks for letting me know.

Do you know what time Mr. Solis asked for water?

A. I can't hear you at all.

Can you guys hear me okay?

MR. KLEHM: I can hear you.

MR. SINCICH: Jinna, can you hear me okay?

COURT REPORTER: Yes, I can hear you.

(Multiple speakers speaking simultaneously.)

BY MR. SINCICH:

Q. Do you know what time Mr. Solis asked for water?

A. I'm just looking at the records that I printed off.

I can't tell you exactly because this note was an addendum. It was done -- this is on Page 9 of the Riverside University Health System records. And the nurse was Nurse Venezuela, but if you look at the entry, it's the status's addendum. So the time was 17:56 or 5:56 p.m., but when it's done as an addendum, that means it was done after the fact.

So when we have a resuscitation or a trauma patient, really, our first goal is to take care of the patient, and then we do the documentation all hands on deck if you're doing things. So I can't tell you exactly what time that was. It had to have been before he was placed on the ventilator when he was still able to talk. He wouldn't be able to talk and ask for water once you're put on a ventilator.

Q. And what time was he placed on the ventilator?

A. Let's see here. They were preparing to intubate at 17:05. I think it was around 17:15. I don't have the respiratory therapy records in front of me, but it was

contemporaneous with that.

Q. Do you know if Mr. Solis was given any pain medication between his arrival at the ER up until 17:15?

A. Pain medication, only he was given for intubation was Ketamine, but he was not given Dilaudid which is a narcotic pain medicine until -- looks like the first dose was given by review of the records at 18:46, so 6:46 p.m.

Q. So prior to being intubated he was given Ketamine?

A. Correct.

Q. And Ketamine is something that reduces pain as well?

A. It does. The level dose was given to him is an anesthetic level dose. So you just go unconscious when you gave that high of a dose. The reason that we use Ketamine in trauma patients is that a lot of the sedation drugs that we use to put someone on a ventilator causes the blood vessels to dilate. So if you have a patient that has any potential -- stability such as a trauma patient, Ketamine is nice because it does not lower your blood pressure when you give it, but it knocks the patient out so you can put them on a ventilator.

Q. Do you know if EMS give him any kind of pain medication in route?

A. I don't think they did.

Q. Are you able to know for sure whether or not they

did or not?

A. I don't believe they did. I don't have the records printed in front of me, but I don't recall that.

Q. Is it possible that if he received pain medication in route and then also received some pain medication in the ER, that his pain would have been reduced?

MR. KLEHM: Objection. Incomplete hypothetical; lacks foundation; calls for speculation.

THE WITNESS: So that's the reason we give pain medication, to help reduce their pain and alleviate suffering. I think another piece of evidence that goes against getting any narcotic or opioid pain medication is the laboratory sample obtained, performed by Biotox.

There was no mention of opioids on there. So if he were given opioid pain medication prior to that sample being obtained, then it would have been detected.

BY MR. SINCICH:

Q. Is it important in your experience in the ER that someone could be complaining of pain, and it not get annotated in the records?

MR. KLEHM: Objection. Incomplete hypothetical as to what level of pain.

THE WITNESS: Could be. Typically, is in the residual chart for all the doctors, but it's possible, yes.

BY MR. SINCICH:

Q. Can someone with Mr. Solis's level of toxicity of PCP and methamphetamine be able to run?

MR. KLEHM: Objection. Incomplete hypothetical; lacks foundation; calls for speculation.

THE WITNESS: Yes. He was conscious. I don't see any reason he couldn't. I mean once the leg was broken, he wouldn't be able to run, but prior to the leg injury, yeah, I guess he could have run.

BY MR. SINCICH:

Q. Would he be able to drive?

A. I don't know. You would have to do a field sobriety test on him to make that kind of determination if he was physically able to drive or not --

MR. KLEHM: Also, sorry. Incomplete hypothetical; vague and ambiguous as to be able to drive.

Sorry, Doctor. I got to interpose objections before you answer, please.

BY MR. SINCICH:

Q. Were you finished responding?

A. I'm sorry. So the question was would he be capable of driving?

Q. Correct.

A. The answer is I don't know. I didn't see any video of what his behavior was like prior to all of this happening. So it's hard for me to give you opinion if he was capable.

I mean he's conscious. Could he turn the key on and push the gas pedal, yes. Would he be successful in driving, I don't know the answer to that.

Q. Do you know whether or not a person with Mr. Solis's level of toxicity of PCP and methamphetamine would be able to understand and comply with commands?

MR. KLEHM: Same objections.

THE WITNESS: Like I said, people on PCP are very variable with their response in terms of their level of cooperation, and I have seen a whole spectrum. So it's hard for me to give you an opinion or not, yes or no, he's capable of responding. He was able to answer questions on his medical history and other information when asked.

So it appears that he seemed to understand information that was coming to him.

BY MR. SINCICH:

Q. He was able to have a conversation, then, despite his level of toxicity?

A. He was able to answer the questions. So yes.

I don't know how detailed the conversation was.

Q. Is it fair to say that the quantitative level of PCP and methamphetamine in his plasma does not correlate exactly to the effects that he would have?

MR. KLEHM: Same objections. Incomplete hypothetical; lacks foundation; calls for speculation; vague

and ambiguous.

THE WITNESS: As I said previously, every person is different in terms of their toxicity with particularly with PCP. Some people are very calm; some people are very wild, and there's everything in between. So it's hard for me to give you an exact answer to the question that you're asking.

BY MR. SINCICH:

Q. But you found evidence that Mr. Solis was calm in this incident; right?

A. Yes.

Q. And part of that variability is because of a person's tolerance to the drugs?

A. There are many factors: Body composition, your percentage of body fat, depending on how the drug is taken, when it was taken.

As I talked about it earlier, if it was taken orally and there's food in your stomach, it can be variable absorption. So there is a lot of different factors.

Tolerance is something what happens with most drugs and alcohol. The more you use it, the more that you can take and the more it takes to get high.

Q. Right. Is it also possible that a person can have a tolerance to a substance naturally, for instance, without ever having taken it before?

MR. KLEHM: Same objections.

THE WITNESS: I would say generally no. Nothing is a 100 percent in medicine, but alcohol, for example, people that are novice drinkers, they have two or three drinks, they're very buzzed. You don't see people that have never had alcohol that drink two or three drinks, and say it didn't affect me at all.

BY MR. SINCICH:

Q. Right. Maybe it's not necessarily that it didn't affect them at all, but I guess what I'm thinking about is if you take two people who had never used PCP before, for example, and then they have the same body composition and they take the same amount in the same method, they can have very variable effects; is that fair?

A. That's fair. I pointed that out previously that --

Q. Right --

A. -- variable behavior with PCP.

Q. One person can just be slightly more tolerant to the drug at that dose than another person?

A. I don't know that it's tolerance or is it clinical effect, or it's a different brain chemistry, what the explanation is medically.

But there is a different clinical picture.

Q. And certainly with repeated use, tolerance can get built up?

A. Yes.

Q. Do you know whether or not Mr. Solis had a tolerance to PCP or meth?

A. I do not.

Q. Is it possible that he did?

MR. KLEHM: Same objections.

THE WITNESS: He was a chronic user, yes.

BY MR. SINCICH:

Q. One of the things you mentioned was body composition.

Is that what you meant by the percentage of fat?

A. Muscle fat, how much water is in your body.

So those are factors with drug distribution, what's in the body. Also, your underlying health condition, your kidney, liver, are they functioning well, there is a lot of different factors.

Q. If a person has a higher fat percentage, what effect does that have on the toxicity level?

A. So drugs that are what we call lipophilic, love fat, people that have a higher body fat composition, more the drug goes into your fat, it stays in there longer than leaches out. So they may not get as high when they take it, but clinical effects last longer because the drug gets parked in your fat, it sits there, and then slowly leaches out.

We see that with marijuana users, for example. It's

a classic example with people who use marijuana and the clinical effects, but it can be used with any drug, and PCP is a lipophilic drug.

Q. So for instance, a person can that use a lipophilic drug and that person having a high body fat percentage could potentially be detected for the drug in their system even though they're no longer feeling the effects of the drug?

A. They probably still have some clinical effect, but it would not be -- the peek effect of them getting stoned would be slower. The drug gets into the system, redistributed into the fat. Now it's not a 100 percent parked there. You still have it in your serum as well, but it leaches out slower.

So rather than seeing a real sharp peek and then down, it is more of a blunted effect. So the high lasts longer, may not get as high. They still get stoned from it, but it's just different in terms of the duration and maximum high that they get.

Q. Okay. And then the water, is a person who has more water, are they more or less affected by the drug?

A. The more water in your system, you would be a little less effected. But again, it depends on the lipophilic nature of the drugs. Meth is very water soluble as opposed to PCP is more of a lipophilic drug.

Q. And then the way in which a person takes the drug,

does that have an effect, we talked before about how quickly it can hit the system, but what about how long it lasts in the system?

MR. KLEHM: Objection. Incomplete hypothetical; vague and ambiguous as to how long it lasts.

THE WITNESS: Vary in generality for drug use.

I think the drug that we have the most experience with in this situation are opioids. So people that -- and I'll use that as an example to all drugs all in the same category. Opioids, people that shoot opioids have an immediate high. That's what we see most of the life-threatening overdoses with heroin or fentanyl because you can reach a maximum blood serum level immediately as soon as you inject it in. Let's take that a smoked form, and the smoked form you can't get as much in per hit.

So as you're smoking the fentanyl or smoking heroin, you can only get so much into your lungs. You can't get a super high concentration because it burns and the fumes are going in. So it takes longer to get high. So it's not as maximum of a high as you do when you inject it. Then the slowest way is an oral ingestion because the drug has to get into your stomach. There's factors like we talked about, food or if there is a lot of water in your stomach, et cetera.

The drug has to be absorbed, go into the blood

stream through your liver. All the foods that in our intestine or drugs or anything else when it gets absorbed immediately goes to the liver to start part of the metabolism and detoxifying. So the blood levels are not as high because the liver breaks down a lot of the drug before it even gets into the blood stream itself, systemic circulation to get to the brain. So the effects generally are blunted both longer when you take it orally as opposed to injected it where it's much faster and wears off faster.

BY MR. SINCICH:

Q. How long generally speaking does PCP last in a person's system?

A. Basically, the rule of thumb is four to eight hours.

Q. And after four to eight hours, is it still detectable in a person's system for a certain period of time?

A. That's a factor how much is in the system when you start. So the more in the system when you start the longer it's going to take for all of it to clear out.

Q. Is it possible then that a person can have taken a drug at a particular dose, for instance, PCP the day before and then it be detected the following day even though they're not feeling the effects of the drug?

MR. KLEHM: Objection. Incomplete hypothetical;

lacks foundation; calls for speculation.

THE WITNESS: I could say no to the following reasons. If they had no clinical effect, you're not going to detect it in the blood. You'll detect it in the urine. So these urine drug screens typically stay positive for five to seven days with most street drugs. The reason that is is your kidney filter the blood and at these metabolic byproducts get into the urine and not brought back.

So your kidney I think your blood runs through it, filters and tox and turn it into urine, but the vast majority of the blood that goes into your kidney and the electrolytes or anything else get reprocessed and pulled back into your system. And so it's -- you're essentially concentrating the drug level under the urine and that's why it's detected longer even though someone may have done it days ago. So if it's detected at the blood stream, then usually there's going to be some clinical effect that you'll notice.

BY MR. SINCICH:

Q. Do you know how Mr. Solis took PCP?

A. No.

Q. Do you know how he took methamphetamine?

A. No.

Q. Do you know when Mr. Solis took PCP?

A. No.

Q. Do you know when Mr. Solis took methamphetamine?

A. The only thing I can give you is the clue to that question -- sorry. I'm just looking at the toxicology report. So if you look at the ratio of methamphetamine to amphetamine in the tox report, methamphetamine is metabolized to amphetamines. So when you see a high level of meth with a much lower level of amphetamine, it's a very recent ingestion because the body has to metabolize it. Whereas, if you see the opposite pattern, so you see a high level of amphetamine, but the meth level is lower, then it's already got to the metabolic process which takes some period of time for that to happen.

Q. When you say recent, do you mean minutes, hours, or what do you mean by that?

A. In a situation like this it would be minutes to hours. I can't say it's 39 minutes or an hour and ten minutes, but it's in the more recent time frame.

Q. And are you able to tell by looking at any of these results or records whether or not the meth or the PCP were taken at the same time?

A. No. There is no way you can determine that.

Q. Do you know what is the average half-life of PCP?

A. The clinical effects is four to eight hours. The half-life itself I think it's about eight to twelve hours, but it stays in your system awhile. It's a long acting drug compared to most other street drugs.

Q. Is it fair to say that PCP is highly variable in its half-life?

A. Depends on the person that the system is in, what their health is like, their kidney, their liver. So yeah, and everyone's different in terms of metabolizers. Some people are rapid metabolizers, some are slow metabolizers for everything that's taken into their body. So yes, the answer to that would be, yes, everybody's different.

Q. So we don't know what the half-life of the drugs that Mr. Solis took in this matter would be?

A. For him, personally, no.

Q. And we've already talked about how dose can affect the effects on the person; right?

A. Yes.

Q. And we don't know the dose of any of the drugs that Mr. Solis took?

A. That's correct.

Q. Is it fair to say that we don't know if Mr. Solis even intentionally took PCP?

MR. KLEHM: Objection. Incomplete hypothetical; calls for speculation.

THE WITNESS: I mean I guess it's possible somebody drugged him, but I'm not aware of any evidence to support that.

BY MR. SINCICH:

Q. In your practice in the ER have you seen cases where someone thought they were smoking, for instance, just marijuana, but it was laced with something else?

MR. KLEHM: Incomplete hypothetical; it's not taken to account if the patient was a known drug user.

THE WITNESS: In that scenario that you just presented, it's almost exclusively in women when there is a guy that has some ulterior motive and wants to use it to sedate or tranquilize them so they can be sexually assaulted, the date rape drugs and it's a common way to do that. Most people do not buy expensive drugs and then sneak it to somebody else unless they have some motivation for doing it. It's almost always women that that happens to.

BY MR. SINCICH:

Q. Right. I remember reading something with regard to fentanyl recently on how people were thinking that they were thinking one substance, but it had fentanyl in it.

Is that something that you've seen in your practice?

A. Heroin, so if you buy heroin thinking with heroin, but it's cut with fentanyl. So yes, I've seen that.

Q. So it's possible that a person can unknowingly be taking the drug?

MR. KLEHM: Objection. Incomplete hypothetical; lacks foundation; calls for speculation.

THE WITNESS: In the fentanyl example, yes. I'm not

done with gas chromatography. So my understanding is those are much more specific, and you don't see the false positives with those like you do with the urine drug screen.

Q. And my understanding is that with drugs like this there is a few different ranges that are discussed like a therapeutic range, a toxic range, and a range of fatal range. Are you familiar with that?

A. I'm familiar with the fatal range, and in the case of PCP and meth, since there is no FDA approval for their use, there is not a therapeutic range for those drugs because there's not a medical indication to use them.

Q. Okay --

A. So you wouldn't be -- you know, some drugs you'll administer them and then check the blood level to make sure the patient is dosed properly, but these are illegal streets drug, so we don't have those kinds of ranges for therapeutic dose.

Q. So in the toxic range is that pretty variable that a person can be in the toxic range and experience very little systems, and another person in the toxic range can experience much more severe symptoms?

A. Yeah, there is a lot --

MR. KLEHM: Incomplete hypothetical.

THE WITNESS: There is a lot of factors with that, but yes, that's true.

BY MR. SINCICH:

Q. Okay. Some of the symptoms of PCP include agitation; is that right?

A. So it's the waxing and waning behavior. They can be calm and they can be agitated, then all the way to the sort of the wild animal running around naked in the street, you know, I've seen all variations of it.

Q. Did you see any evidence in the records of Mr. Solis going from a calm state to a wild state?

A. No. The only description is that he was in and out of consciousness.

Q. Okay. Do you know if besides him going in and out of consciousness, whether or not he experienced any kind of altered state of consciousness?

A. Altered state of consciousness would be that your consciousness is not normal, and if he's out of consciousness, that is altered by definition, so yes.

Q. Okay. Maybe what I'm thinking of is like hallucinations or delusions.

A. I didn't see anything described in the records that he was actively hallucinating.

Q. Outside of during transport and in the trauma bay where he was going in and out of consciousness, did you see any evidence of him being in a catatonic state?

A. Catatonic -- well, if he was out of consciousness,

that would appear catatonic. Catatonic is just somebody that doesn't move, their eyes may be closed, not respond to any kink of verbal stimulation.

Q. Do you know when he went out of consciousness how long that lasted for?

A. It's not described in the medical records, no.

Q. It could have been like instantaneous, half of a second?

A. I don't know how long it was. I'm not going to guess if it was half a second or five minutes.

Q. Do you know how many times he went out of consciousness?

A. I don't. It's mentioned in multiple people's documentations, physicians and nurses, so several people observed it, but I don't know how many times it happened.

Happened enough that they put him on a ventilator.

Q. Do you know precisely why they put him on a ventilator?

A. Well, the standard protocol for trauma patient that's got multiple gunshot wounds that has any fluctuation of level of consciousness is to put them on a ventilator. The last thing you want as you're doing your diagnostic studies like CAT-scan or X-ray or other testing is for them to go out and stop breathing or to vomit and aspirate.

So any patient like this it's very common to put

them on a ventilator. If we suspect drug use on top of it or if there is any concerns there, it's even a lower threshold for putting them on life support. We give them heavy tranquilizers, put then on a ventilator. It's for their own safety until we can all get these injuries sorted out.

Q. Did you see any evidence from the records of nystagmus?

A. Nystagmus, no one mentioned anything on his eyes other than his eyes were open in the Glasgow scale.

Q. Any evidence of psychosis?

A. Just the waxing level of consciousness, but otherwise, no.

Q. Any evidence of muscle rigidity?

A. Muscle rigidity, that would be kind of hard to assess because of all those extremity fractures, but no, I didn't see those words, muscle rigidity, no.

Q. Any evidence of uncontrolled movements?

A. Uncontrolled movements, no mention of that in the records.

Q. Or seizures?

A. No seizures were mentioned in the record.

Q. What about ataxia?

A. A what?

Q. Ataxia?

A. Well, you have to get up and walk. So you wouldn't

be able to assess for ataxia.

Q. Are all of those things that I mentioned there common symptoms of PCP?

MR. KLEHM: Incomplete hypothetical --

THE WITNESS: They can be seen -- they can be seen, but the presentations are very variable.

BY MR. SINCICH:

Q. Now, part of your opinions is that 60 to 70 percent of his total blood volume was replaced.

Do you see that in your report?

A. Yes.

Q. Do you know how much blood he lost?

A. How much he lost, no, I can't. Nobody measured that. So I don't know that anybody knows that.

Q. Do you know how much his total blood volume he had prior to being shot?

A. Someone of his size would be about five liters.

Q. But we don't know a more precise number, just the average person of his approximate size?

MR. KLEHM: Objection. Argumentative.

He just answered, Counsel, what Solis's approximate blood volume was. And now you're asking him for a more specific number. He gave you an answer.

MR. SINCICH: I'm asking if he knows a specific number for Mr. Solis from his review of the records --

MR. KLEHM: That's what he -- that's what he gave you, five liters, based on Mr. Solis's size. That's what he said.

You can answer again.

THE WITNESS: These are statical average just based on someone of his body, approximately how much blood volume they have.

BY MR. SINCICH:

Q. And what is Mr. Solis's height and weight to your knowledge?

A. I don't know right off the top of my head.

Q. Did you find that in the medical records in order to come up with an average of five liter for a person his size?

A. Yeah. It was his medical records.

Q. How did you determine that 60 to 70 percent of his total blood volume was replaced if we don't how much blood he actually lost?

A. So if he had five liters of blood, then he gets IV fluids by the paramedics, IV fluids by the nurses in the trauma room. He gets transfused two units of packed red blood cells, given two units of fresh frozen plasma. And those have to be diluted. So for example, when we give what is called the packed red blood cells, that's when you go and donate blood at the Red Cross, they take your blood and

separate it. I don't know if you've ever seen blood tube, but down at the bottom it settles down. Those are the red blood cells. So those are concentrated, and that's what is transfused, but it's very thick.

So you got to put intravenous fluids with that when you do the transfusion because it will plug up the IV lines if you don't. So they factor all that in. It's my estimate he had probably two and a half to three and a half liters of total fluid volume placed back into him, and that's why I come up with that.

Q. How much of that fluid volume in your estimate is from IV fluids as opposed to transfused blood either from the packed red blood cells or frozen fresh blood?

A. I would have to go back and look at the exact volume of the packed cells. The packed cells and the FFP are probably the four units are probably close to one to one and a half liters. They're usually about 250 to 350cc' in each bag. It would be in the medical records, but it's not something that I wrote down in front of me.

Q. Is it fair to say that each facility has a different measurement of how much is contained in one unit?

A. Every unit is different. It says specifically on the bag 355 milliliters of blood. There is an exact volume that's on there on the bag, and every bag's different depending on the donation and how much blood is collected.

Q. Did you see exact volumes annotated in the medical records for two units of packed red blood cells?

A. I believe the packed cells and the fresh frozen plasma all had volumes on them.

Q. And what was that volume annotated as?

A. It would be annotated in milliliters.

Q. Right. How many milliliters did each unit have that he received?

A. I told you I would have to go look at the records. I don't have it written down in front of me.

Q. Okay. Let me see if it's in the notes or anything like that that you might have provided.

Do you know if you wrote them down in your notes?

A. I just wrote two units of packed red blood cells, two units of FFP, and -- but I didn't right down like a volume.

Q. Do you know when the transfusion took place?

A. They started when he was in the trauma room.

Q. What time did they start the transfusion?

A. I don't know right off the top of my head.

Just looking at the nurses notes -- Bates Page 12, 17:08 one unit FFP started, 17:07 two units packed red cells per Dr. Albiei. And there is another FFP given after that. I don't have the time for that one.

Q. So the blood transfusions occurred from 17:07 and

beyond?

A. Yes. It may have actually been started sooner than that. Remember, the charting and documentation sometimes lag in trauma patients, you know, because it takes two nurses to set up the whole blood transfusion thing. And so patient care first, then documentation. We try to get the exact times, but they can lag.

Q. Do you have any evidence of lag in this case?

A. As I mentioned before, yes. The nurse put there was an addendum, and so that's an example of lag.

Q. Is there any evidence of lag in terms of the timing of the transfusion?

A. I doubt it because he hadn't been there very long when these times are entered.

Q. When did the medical staff take the blood that was ultimately given to Biotox Laboratories?

A. I can't tell you exactly when that specimen was obtained. That would probably be in the police report. Usually, the police would document that because they're the ones that take custody of any blood samples to go for any kind of testing like that. That's been my experience working in the trauma room or in ER.

Q. Do you see Biotox report? Do you have that in front of you?

A. I do.

Q. Do you see how it says the specimen was collected at 15:05?

A. Yes. And that's not possible because he wasn't even in the ER at that time.

Q. Right. Did you see evidence that there was, I think, they call it a rainbow draw; is that a common term in the ER?

A. Yeah. Rainbow draw it just means you get multiple blood tubes, different color blood tubes, different laboratory tests. So when you say rainbow, you get kind of one of everything.

Q. When did they do his blood draw in the ER?

A. It would be right when he arrived. I don't know right off the top of my head an exact time, but it's very early priority in the resuscitation.

Q. Do you know if they did the blood draw prior to 17:07 when they started the transfusion?

A. Yes. You would have to because if we don't draw the blood before we start transfusing blood, it would mess up future blood typing that has to be done. So everybody's got a blood type, right? And the universal blood -- say you came in with a gunshot wound and you need a emergency transfusion, even though we don't know your blood type, we give you O-negative blood, kind of the universal blood. So the problem is if we transfuse with O-negative and then draw your

blood and send it to a laboratory for typing for additional blood, they're going to have a hard time figuring out what your blood type is because it's going to come up as -- let's say you're A-positive, they're going to check A-positive and O-negative blood. So it has to be -- blood has to be obtained before we start the transfusion.

Q. So you stated in your report that because of the transfusion, and I'm trying to find it exactly where you stated, but you sate that the PCP and amphetamine levels would be doubled or triple what was determined by Biotox because it was diluted by the transfusion.

Do you recall that?

A. Yes.

Q. Is it fair to say that it wouldn't be diluted by the transfusion if the blood draw occurred before the transfusion?

A. If it occurred before that, it would only be IV fluids alone that was given so there would be less of an effect. It was my understanding from looking at the records that this was done after the blood transfusion, but I can't tell you -- there is not an exact time anywhere. There is this time that's on the Biotox report, but that was before he was even at the hospital.

Q. Is it fair to say that you don't know whether or not Mr. Solis's blood toxicology altered because of the blood

You got blood that comes out that's got the drug in it now it's been replaced with something that has new drug. So the calculation gets a little more complicated unless you have the exact volume of blood that's lost, and nobody can measure that when someone's bleeding and they just -- the you're not collecting the exactly you know 571 milliliters of blood.

Q. So is it fair to say that we don't know how much Mr. Solis's blood was diluted, if at all?

A. It was definitely diluted. We know because of his blood pressure being down. He lost blood. There is no doubt because it would not be another explanation. PCP and meth would normally make your blood pressure go up, not down.

And so there was nothing else in the system that would cause his blood pressure to drop. The only thing that would cause that would be blood loss from hemorrhagic shock from the shooting and subsequent blood loss.

Q. But we don't know how much is diluted?

A. I can't give you an exact number as I explained because I don't know how much blood actually came out of his body. I know that he's got significant hemorraghic shock to the point that it lowers your blood pressure.

Q. Okay.

MR. KLEHM: Counsel, we've been going for over an hour. Is there a good time for us to take a break?

MR. SINCICH: I don't have much longer so if you guys want to hang in there for maybe five more minutes, I think I might be able to finish up.

THE WITNESS: Okay.

MR. SINCICH: Is that okay with you, Jinna?

MR. KLEHM: Yeah. I'm going to have some follow-up questions. So Jinna might want to take a break at some point?

MR. SINCICH: Okay. Let's go off the record.

(Discussion held off the record.)

BY MR. SINCICH:

Q. Doctor, is it your opinion that Mr. Solis did not experience the pain of being shot?

A. I think that there was some pain, but I think the effect was very blunted for him. I don't think it was zero pain because he did yell out, "my leg." But for him to be calm and the way they described him in the trauma room, given the number of injuries that he had, and all those broken bones that are extremely painful, it didn't match up from what my experience to be taking care of a lot of trauma patients.

Q. Do you have a percentage of how much his pain was numbed by the drugs?

A. I would say probably more than 75 percent, at least, maybe could be even more than that.

Q. And how do you determine that?

A. Well, it's just kind of a medical analysis. It's not something that's quantitative we can measure like a heart rate or a temperature, but him not requesting pain medicine and asking for a glass of water is not really consistent with someone that has all those injuries if they were clinically sober. Is it possible he wanted water, sure, but they would be asking for paiN medication or indicating that they're in agonizing pain.

Q. And you said that you saw evidence that he was actually complaining of pain on-scene; right?

A. All he said was, "my leg" that was on that Ring video.

Q. Are you aware that there is body-worn camera video that shows a portion of the shooting and immediately thereafter?

A. No.

Q. Would it surprise you --

MR. KLEHM: Counsel, it's vague.

Now you're being argumentative, Counsel. The body-worn camera was not worn by the CHP officer; you know that.

MR. SINCICH: I didn't say that it was.

MR. KLEHM: Right. You're referring to -- it's vague and ambiguous. You're not describing what shooting

you're referring to, whether it's my client or someone else.

MR. SINCICH: Okay. All right.

BY MR. SINCICH:

Q. Are you aware that there's body-worn camera video that shows him within 30 seconds after the shooting?

A. No.

Q. Would it surprise you if that body-worn camera showed Mr. Solis screaming in pain?

MR. KLEHM: It's argumentative. He just said what he heard Mr. Solis yelling out about his leg.

THE WITNESS: I would have to see the video to see what his response was. It's hard for me to say anything more without seeing it.

BY MR. SINCICH:

Q. Would it surprise you to hear that there was officers on-scene that testified that they saw Mr. Solis in pain on-scene?

MR. KLEHM: Objection. Vague as to time.

BY MR. SINCICH:

Q. And I'll be more specific.

After the shooting and before EMS arrived, officers saw Mr. Solis in pain?

MR. KLEHM: Okay. It's still vague as to time as to shooting, which shooting you're talking about.

BY MR. SINCICH:

Q. Would it be surprising to learn that based on your assessment of the records?

MR. KLEHM: Vague and ambiguous as to what shooting you're talking about.

THE WITNESS: From what I've seen in the records, I didn't see anything that indicate that he was in agonizing pain which I would expect after this type of injury. So I would be surprised to see that, but without seeing the video, I can't really give you a more definitive answer.

BY MR. SINCICH:

Q. Okay. Now in your report you also mentioned that Mr. Solis, and I believe you mentioned it earlier, required multiple shots in order to surrender.

Do you recall that?

A. Yes. He was shot multiple times, yes.

Q. And which officer are you referring to when you said that he was shot by that officer before surrendering?

A. I can't give you an opinion on that.

I don't know.

Q. How do you define surrender when you say surrender in your report?

A. To me surrender means that you put your weapon down and are following commands and what the police officer is asking or when you're incapacitated and to secure the scene.

intervene and treat the drug intoxication as well. So we're treating the actual wounds. We got to stop the bleeding, secure the airway, get the blood transfusion, do all the diagnostic tests to figure out what the injuries are.

So that process is exactly the same, that they're high on drugs or they're sober. Unfortunately, you're working in the trauma center, we see a lot of drug and alcohol tied in with people that come in. They're victims of either violent trauma or self-conflicted trauma or car accidents or things like that.

And it's rare that we have to do an intervention on behalf of the drugs, and probably the one exception would be opioids where we may have to give if they stop breathing called Narcan.

Q. All right. Now you had mentioned before that Mr. Solis was prophylactically put on a ventilator so that he didn't go unconscious during the diagnostic testing and treatment; correct?

A. I think it's beyond -- when I say the word prophylactic, it's just that we're being aggressive as doctors anticipating that there is a potential for significant deterioration given that his heart rate is 150 with these multiple gunshot wounds that he has because you don't know what the injuries are. All you know is there's holes all over the place. You don't know where those bullets

have traversed and wound up until you do all the diagnostic testing.

Q. And would being put on the ventilator also be due to Mr. Solis possibly being on drugs, PCP?

A. Well, he's going in and out of consciousness, and it's not because his blood pressure is dropping below 60. So it's sort of a maybe yes, that may be some factor. I don't know -- you know, there was not mentioned that specifically in the notes from the doctors there.

Q. Now, you had mentioned earlier about the blood drawn, the time of the blood being drawn that was eventually sent to Biotox Laboratories.

Do your opinions about the dilution ratios mentioned in your report, are they supported by the fact that the blood was drawn on a Wednesday, March 2, 2022, the same day that Mr. Solis was admitted to the hospital at 23:2400 hours which would be 11:24 p.m?

MR. SINCICH: Misstates facts; assumes facts not in evidence.

THE WITNESS: I want to make sure I understand the question. You're saying that the labs were obtained at --

BY MR. KLEHM:

Q. I'm saying that -- yeah, according to the police records, the blood draw which was eventually sent to Biotox Laboratories was drawn on Wednesday, March 2, 2022, at

23:2400 hours.

MR. SINCICH: Sounds like Counsel is testifying outside of the records reviewed by Dr. Ritter, not a basis for his opinion; assumes facts not in evidence.

THE WITNESS: I didn't see what time it was drawn. I told you that.

BY MR. KLEHM:

Q. But your opinion as to the dilution ratio was based on the presumption that the blood draw specifically that was sent to Biotox Laboratories was drawn after Mr. Solis had received the transfusions that you had discussed which began to be administered around 5:00 or 5:07 p.m.

A. That's correct.

Q. Okay. All right. So if the blood draw that was sent to Biotox which your opinions are based on, was taken approximately six hours later, then that would be consistent with the opinions expressed in your report; correct?

A. Yes.

Q. Okay. All right.

I don't have any further questions.

Thank you very much, Dr. Ritter.

MR. SINCICH: Okay. I don't have any further questions at this time.

Jinna, do you need anything before we go off the record?

COURT REPORTER: No spelling questions.
Does anyone need to order copies of the transcript?
MR. KLEHM: Yes. I would like a copy, please.
(Deposition proceeding concluded at 11:46 a.m.)

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